ATTACHMENT 4.18-C Page 1 OMB NO.: 0938-0193

Supersedes
TH No.

Approval Date

HCFA ID: 0053C/0061E

Effective Date

10-1-85

Not applicable.

Service

Deduct.

Type of Charge Coins. (

Copay.

Amount and Basis for Determination

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

| e following charges are impo | Sta |
|--|----------------|
| following charges are imposed on the medically needy for services: | State: Indiana |

| HCFA-179 #_85-14 | Date | Rec'd | إحا | 1/8 | 5 |
|------------------|------|-------|-----|-----|----|
| Supercedes | Date | Appr. | 12 | 113 | 83 |
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| State Rep. In. | Date | LII | | | |

Revision: HCFA-PM-85-14 (BERC) OFFICIAL SEPTEMBER 1985

ATTACHMENT 4.18-C Page 2

| | STATE | PLAN UNDER | TITLE XIX C | OF THE SOCIAL | SECURITY ACT | | | |
|-----|--|------------|----------------|--------------------------------|-----------------|-------------|--|--|
| | Sta | te: | Indiana | - , | | | | |
| В. | The method used individuals: | to collec | t cost shari | ng charges fo | r medically ne | edy | | |
| | / Providers from indiv | | sible for co | llecting the | cost sharing c | harges | | |
| | | | | the full Medi arges from in | caid rate for a | services | | |
| C. | The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below: | | | | | | | |
| | Not applicabl | e. | | | | | | |
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| Bup | No. 85-14 ersedes | Appro | val Date | | Effective Date | 10-1-85 | | |
| TN | No | | | | | 0053C/0061E | | |
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| | | | 10EA 170 11 2C | S-14_ Date Rec | -4 12/1/8< | | | |
| | , | | | Date Red | | | | |

State Rep. In. _____ Date Eff. _______

Cumulative maximums have been established as described below:

Approval Date _____

HCFA-179 # 85-14 Date Rec'd

Supercedes _____ Date Appr.
State Rep. In. _____ Date Eff. __

Effective Date _10-1-85

HCFA ID: 0053C/0061E

Not applicable.

TN No.

Supersedes TN No.